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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon copies. Page 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 09385

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
William James Morris, SR.						3-21-85				1:10 P.M.		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						
Male		Caucasian	MONTH	DAY	YEAR	IF UNDER 1 YEAR		IF UNDER 24 HRS				
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Hartford County		United States			Queen Anne's County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
Centreville		Meridian Nursing Center-Corsica Hills			(RET) FARMER					FARMING		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Kent		Chestertown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD# 4 Box 376A 21620			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	ADDRESS			
Sheridan J. Morris					Lisa				SINGLETON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		215-32-2517			Clara Morris RD#4 Box 376A Chestertown, MD 21620		5 yrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Renal Insuff COPD. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-12-85, 19_____, to 3-14-85, 19_____, that (I) (we) last saw the deceased alive on 3-14-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED	
22b. SIGNATURE					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	3-21-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		John R. Smith, Jr. M.D.			22e. ADDRESS		Centreville, Md 21617					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY			STATE
BURIAL		26 MARCH 85		ROCK RUN CEMETERY			ROCK RUN, HARFORD CO., MARYLAND					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078					MAR 26 1985		Lawson-Fordell					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be mailed to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

A

MEDICAL CERTIFICATION

STATE OF MARYLAND, DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 5 0 9 3 8 6
1. DECEASED NAME (TYPE OF PRINT)					REG. NO.
FIRST MIDDLE LAST					
LAWRENCE P. STRONG					
2. SEX male	4 RACE white	5. DATE OF BIRTH August 22, 1885	2a. DATE OF DEATH March 20, 1985	MONTH DAY YEAR	2b. HOUR 1 P.M.
6. BIRTHPLACE Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>	6. AGE (IN YEARS LAST BIRTHDAY) 99	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 2 HRS HOURS MIN.
10. CITY OR TOWN OF DEATH Sudlersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kitty's Domiciliary Home			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne Co.	
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Auto Dealer	12b. KIND OF BUSINESS OR INDUSTRY MD.	
13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE High St. 21620		
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Walter B. Strong	Belle Price				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 07 6963	17. INFORMANT Mary Jean Comegys	ADDRESS High St. Chestertown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure					
DUE TO, OR AS A CONSEQUENCE OF (b) Age					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) Ashuing years					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 days					
5 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) <input type="checkbox"/> hospital attended the deceased from 1-1, 1980 , to 3-20, 1985 , that (I) <input type="checkbox"/> last saw the deceased alive on 2-16 1985 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE A. C. Dick	DEGREE W.H.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-21-85		
22d. PHYSICIAN'S NAME (TYPE OF PRINT) A. C. Dick	22e. ADDRESS Chestertown, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/22/85	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery near Chestertown, Md.	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE
24. FUNERAL DIRECTOR NAME Willie Wells	ADDRESS Chestertown, Md.	25a. DATE READ BY REGISTRAR MAR 26 1985	25b. REGISTRAR'S SIGNATURE J. L. Bender		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, medical personnel must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 9 3 8 /									
												REG. NO.									
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR									
			META			Tiedemann			3 - 20 - 85			842 P.M.									
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
						Dec 5, 1901			83												
7a. BIRTHPLACE Germany			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne Co.			10. CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridan (Corscia Hills) Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY MD.	
13a. STATE Md.			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1127 Mainsail Drive			21403						
14. FATHER'S NAME FIRST William			MIDDLE Hunke			LAST			15. MOTHER'S MAIDEN NAME FIRST Unk			MIDDLE			LAST Ardler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT Frances Minter			17. ADDRESS Annapolis Md 21403			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
no			087 38 3087									3 yrs +									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))												Sec. Osteoporosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b)									
												DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN												
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> , 19 <u>84</u> , to <u>Mar. 20</u> , 19 <u>85</u> , that (II) (we) last saw the deceased alive on <u>Mar. 13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/30/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J.H. Ardler</u>																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/21/85			23c. NAME OF CEMETERY OR CREMATORIUM Silverbrook Cemetery			23d. LOCATION Wilmington, Del.			23e. STATE									
24. FUNERAL DIRECTOR NAME <u>Willie Wells</u>			24b. ADDRESS Chestertown, Md.						25a. DATE REC'D. BY REGISTRAR MAR 2 6 1985			25b. REGISTRAR'S SIGNATURE <u>Suzanne K. Ardler</u>									

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IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 0 9 3 8 8								
										REG. NO.								
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			William Leon			WALBERT (Sr.)			March 9, 1985			9 P.M.						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS				
Male			white			June 20, 1897			87			YRS.		MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Kent Co. Md.			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Queen Anne Co.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Centreville			Corscia Hills Nursing Center			Store (Variety) Owner												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e STREET ADDRESS / ZIP CODE								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21645						
Maryland			Kent			Kennedyville						Kentmore Park						
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME												
James Joseph Walbert						Elizabeth Larrimore												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			Radcliffe Drive						
yes WW 2			213 14 1624			Leon Walbert, Jr.						Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Ca prostat with circl- spread metastasis										3 years								
DUE TO, OR AS A CONSEQUENCE OF (b)																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)																		
DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3/2 1985 to 3/9 1985, that (I) (we) last saw the deceased alive on 3/7 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22e. DATE SIGNED 3/11/85								
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			C.G. BAEMANN			22e. ADDRESS			Chestertown, Md. 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE					
Burial			3/13/85			Chester Cemetery			Chestertown, Md.									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Willis Wells			Chestertown, Md.			MAR 13 1985			Gloria Davidson-Randall									

